



What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT



Vol. 1, No. 1, August 2001

Navrongo Health Research Centre

HEALTH FOR ALL IN SIGHT

THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Introduction

It is a common claim that community health and family planning programmes in sub-Saharan Africa are not working. Questions concerning “what to do” in response to evidence of programme implementation problems remain the subject of considerable discussion and debate. With international financial support, programmes have often been launched that have no guidance from scientific trials. For example, the “Bamako Initiative” has been launched to make health services conveniently available through village committees, health volunteers, and revolving accounts for sustaining the flow of drugs for primary health care.¹ Also, “Community-based Distribution” (CBD) of contraceptives has been proposed as the best means of providing convenient low-cost family planning services. While these ideas are appealing, no systematic evidence exists to support the view that fertility and mortality can be reduced with these approaches. Does the Bamako approach work? Does CBD reduce fertility and ensure child survival? What is the best way forward for developing affordable and sustainable community health care? What should be the components of a community health system that works?

Health for All

In 1978, the World Health Organization convened the Alma Ata Conference to address similar concerns and to develop a consensus that “Health for All” could be achieved by the year 2000. Achieving “Health for All” through village-based Primary Health Care (PHC) became the official goal of the Government of Ghana. Yet, by the early 1990s mounting evidence showed that Ministry (MOH)PHC coverage for the country was low. Modern contraceptive uptake goals, particularly for family planning, were not being met. Building health facilities at the village level (Level A) had never been part of the government’s strategies to decentralize health services. In any case, that would have been too expensive to sustain as a national programme. Community Health Nurses (CHN) who had been trained for community work remained based in sub-district (Level B) clinics that were inaccessible to a large proportion of rural households. It was time to take health care services to the doorstep of the people and involve them in the design and implementation of health policies. Following this new thinking, a series of focus group studies was organized by the Ministry of Health to find out why health service utilization was low and why family planning uptake specifically, was not progressing. Respondents appealed for health care strategies that, in the words of one woman, would “first make sure that our children do not die.” Child survival thus became crucial to the acceptance of family planning. In addition to this precondition, respondents wanted service approaches that would respect their concerns about privacy. Women appealed for approaches that would put men at ease about family planning.



**CHFP staff and community members
discussing ways of improving health
service delivery in rural Ghana**

Link to Policy

The Navrongo Health Research Centre (NHRC) has a mandate from the MOH to investigate health problems of the Sahelian ecological belt of northern Ghana. The Centre was asked to take the next step beyond the focus group studies to develop a package of services that would respond to the expressed needs of the people and test the impact of this health development

¹ The “Bamako Initiative” is the outcome of a UNICEF-sponsored regional health conference on sustainable primary health care delivery. It involves convening health committees at the village level, training health service volunteers, distributing primary health care drug kits, and operating a revolving fund for covering the cost of replenishing supplies as services are rendered. Three elements of the scheme are required to make it work: A logistics system for replenishing supplies; a financial system for managing the flow of resources; and a volunteer system for providing and supervising village-based health care.

programme on fertility and child survival. Although there was unanimity on what needed to be done, there was no consensus on how to proceed. Some policymakers advocated retraining, reorienting, and relocating CHN in ways that would make community health care a reality. Others were of the opinion that only volunteer services could be affordable and practical. Volunteer services, while representing an appealing concept, had, in the past, failed to produce satisfactory results. Debate about what to do with poorly functioning PHC village nurse and village volunteer strategies was at the core of the view that an experiment was needed. By virtue of its research mandate and reputation, the NHRC was requested to carry out the experiment and Kassena-Nankana District became the site of this trial. The overall goal of the experiment was to improve coverage and quality of health care services. Specific questions were asked by the MOH that could not be resolved without evidence from a field trial:

- Is there a way to develop sustainable and effective volunteer components of the health care programme?
- Is there a way to mobilize CHN so that they are truly community-based health care providers?
- Can CHN mobilization and volunteerism be developed jointly in ways that improve upon the effectiveness of deploying CHN and volunteers separately?
- What are the costs and marginal benefits of each option?

Phase I: Consulting with Communities about CHFP Operations

The NHRC, with support and approval from the MOH, embarked on a series of consultations with the Chiefs and residents of the Kassena-Nankana District. The community members made constructive suggestions that helped in the design of the experiment that eventually became known as the Community Health and Family Planning (CHFP) Project or simply, *The Navrongo Experiment*. Discussions continued and services were changed and adapted to community opinion, reactions, and advice. In this way, concerns about promoting the survival of children, addressing the needs expressed by women for family planning, and respecting concerns of men could guide the actual activities of the programme as it was developed in a micro pilot.

Phase II: An Experimental Trial

Over the initial 18 months of the project, services were launched in three pilot villages where community members served as consultants in the design and implementation of the service delivery scheme meant to respond to their expressed needs. The

experimental trial was meant to seek answers to the following questions: was the design of the experiment appropriate? Will nurses agree to go to villages, live and work among the people? Will volunteers live up to their new tasks? How will community members respond to the new health service delivery? A great deal of care was taken to ensure that the ensuing design was culturally sensitive, appropriate, acceptable, affordable, and accessible. Once the overall system of culturally appropriate care was developed, the experiment went to scale in the entire Kassena-Nankana District in 1996. The reasoning was that community members had a fair idea about what would work and what would fail. The next challenge was to learn how to improve community health services and how to effectively deliver them as a package to communities and districts. Large-scale trial permits observation of the impact of a community-planned and culturally appropriate system of care.

Conclusion

Programmes launched with the aim of decentralising access to PHC in rural communities—where the majority of people in many parts of the world live—have been based on speculation. *The Navrongo Experiment* has been

designed to test hypotheses that give scientific bases for such programmes. Numerous and varied lessons from the experiment attest to the feasibility of the project and make the experiences worth sharing with others, not only in Ghana, but elsewhere around the world.



**A woman expressing her views
at a focus group discussion**

Send questions or comments to: What works? What fails?

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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made the *Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.